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DRAFT

INSTRUCTIONS FOR COMPLETING THE MEDICARE ADVANTAGE PLAN BID FORM FOR CONTRACT YEAR 2006

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Table of Contents

Introduction

Medicare Advantage (MA) organizations (and organizations offering Social HMOs) must submit a separate bid for each plan that it offers to Medicare beneficiaries. In the case of a local plan with more than one service area segment, a separate bid must be submitted for each segment. The bid must be submitted to the Centers for Medicare & Medicaid Services (CMS) on the provided form. This bid form should not be completed for MSA, Cost, PACE, and certain demonstration plans.

Additionally, MA organizations must give CMS supporting documentation as described throughout these instructions and in the Supporting Documentation Appendix. The submitted bids will be subject to review by CMS. All data submitted as part of the bid process are subject to audit by CMS or by any person or organization that CMS designates.

To complete the bid form, MA organizations must provide a series of data entries on the appropriate form pages. The number of inputs depends on the type of plan and how long it has operated.

The following describes the most common steps in completing the MA bid form. It involves an MA plan that has credible experience data. The MA organization (MAO) must:

- Report the Medicare base period allowed costs.
- Enter the estimated adjustments needed to project the base period costs to the contract year.
- Report the estimated cost sharing values for the contract year.
- Compute the benchmark, rebate, and member premium (in the case of regional plans, these amounts will be estimated until CMS determines the plan bid component of the regional benchmark).

MA organizations that do not have base period costs (or do not have fully credible experience) must enter a manual rate that estimates the Medicare costs for the contract year.

MAOs must use the CMS bid form to develop a pricing structure for each MA plan. Organizations must submit the information in the CMS-approved electronic format.

See Appendix C regarding the bidding process for MA plans covering Part B-only enrollees.

If you have any questions about the content of the bid form, please email them to CMS at **actuarial-bids@cms.hhs.gov**.

Note: Any data entries included in the bid form are for illustration purposes only.

General Overview

The MA bid form replaces the previous adjusted community rate (ACR) worksheet. These instructions highlight the biggest changes from the ACR process and provide guidance in completing the new bid worksheet.

The new bid form is organized as outlined below:

Worksheet 1 - MA Base Period Experience and Projection Assumptions
Worksheet 2 - MA Projected Allowed Costs PMPM
Worksheet 3A - MA Projected Cost Sharing PMPM (in-network)
Worksheet 3B - MA Projected Cost Sharing PMPM (out-of-network)
Worksheet 4 - MA Projected Revenue Requirement PMPM
Worksheet 5 - MA Benchmark PMPM
Worksheet 6 - MA Bid Summary
Worksheet 7 - Optional Supplemental Benefits

All worksheets need to be completed, with the following exceptions:

- If the plan does not offer out-of-network benefits (for ex, an HMO), then Worksheet 3B should be left blank.
- If the plan does not offer any optional supplemental benefit packages, then Worksheet 7 should be left blank.

All plans must also complete the two-year-lookback form and submit an actuarial certification. If the plan includes prescription drug benefits under Part D, then an *additional Rx bid form* must be completed.

The separate Rx bid form prices Part D prescription drug benefits offered by the plan. While any supplemental benefits (either prescription drug or A/B) offered by the plan may be viewed as a single package of supplemental benefits, the two types of supplemental benefits are considered separately for bidding purposes.

The following sections contain instructions on how to complete the bid form. Line items are explained with user inputs noted. In addition to the line-by-line instructions, there is also a glossary to assist the user with unfamiliar terms. The benefit description report available from CMS's Health Plan Management System (HPMS) may also be helpful. The report has been updated to reflect the revised MA categories included in the bid form.

The following comments compare and contrast the new bid form to the ACR process:

- Non-Medicare information is not collected. As a result, the allowable costs are developed directly from Medicare base period experience and projected trends.
- The pricing for optional supplemental benefits is separate from the bid for mandatory benefits.
- Worksheet 1 is similar to ACR Worksheet B, except that costs are shown in total instead of by statutory benefit category. Also, the projection factors are explicitly provided.
- The bid allows the use of credibility weighting of experience data and a manual rate.

- Experience and projected costs are presented in total for in-network and out-of-network in Worksheets 1 and 2. Worksheets 1 and 2 are for total benefits; this is split out later between Medicare-covered and A/B mandatory supplemental benefits in Worksheet 4.
- Worksheet 3 is similar to ACR Worksheet C in that cost sharing data is provided. However, the entries do not need to be for each individual PBP category. Also, additional data is shown regarding the development of the PMPM values, which previously was shown in separate supporting documentation.
- Actuarial certification is now required and must be submitted electronically.
- Maximum premium calculation for Part A benefits offered on Part B-Only plans (ACR Worksheet C1) has been simplified.
- Because of the complexity of the bid process, a section has been included on the Bid Summary worksheet that illustrates the projected income statement.

It is important to note that rounding must not be used when entering data into the bid form. The only exception is: enrollment headcounts on worksheet 5 and the Allocated Rebate section on Worksheet 6 must reflect rounded entries.

Note: Any data entries included in the bid form are for illustration purposes only.

Worksheet 1 - MA Base Period Experience and Projection Assumptions

This worksheet summarizes the base period data and the key assumptions used to calculate the projected allowed costs for the MA plan. Section I includes general plan information that will be used in other worksheets. Section II includes base period background information. Section III summarizes the base period data for the MA plan and Section IV illustrates the factors used to project the base period data to the contract period. All information provided on worksheet 1 should exclude ESRD enrollees.

SECTION I - GENERAL INFORMATION

Line 1 – Contract Number. Enter the contract number for the plan on line 1. The designation begins with a capital alphabetic letter H and includes four Arabic numerals (for example, H9999). Please include all leading zeros. Obtain this number from your contract.

Line 2a – Plan ID. The plan ID and corresponding contract number form a unique identifier for the plan being priced in the bid form. Plan IDs contain three Arabic numerals. Please enter all leading zeros. If the bid is for an employer-group only plan, the plan ID must be 800 or higher.

Line 2b – Segment ID. If the bid is for a service area segment of a local plan, enter the segment ID.

Line 3 – Contract Year. This cell is preloaded with the calendar year for which the contract applies.

Line 4 – Organization Name. Enter the organization's legal name on line 4.

Line 5 – Plan Name. On line 5, enter the name of the MA plan you are offering to Medicare enrollees. This need not exactly match what is in the PBP. It is only used as an identifier for the user's benefit.

Line 6 – Plan Type. Enter the type of MA plan - the valid options are listed below. Plan types are provided for plans without Part D and with Part D coverage. Please note, as indicated above, this bid form should not be completed for Cost, PACE, MSA and certain demonstrations. An MAO must offer at least one benefit plan of any plan type that includes Part D coverage for each service area, except for PFFS plans.

Type of Plan	**Without Part D:**	**With Part D:**
Coordinated Care Plans:		
Health Maintenance Organization	HMO	HMO-D
Health Maintenance Organization with a Point-of-Service (POS) Option	HMOPOS	HMOPOS-D
Provider-Sponsored Organization	PSO	PSO-D
Preferred Provider Organization	PPO	PPO-D
Regional Preferred Provider Organization	RPPO	RPPO-D
Private Fee-for-Service Plan	PFFS	PFFS-D
Social HMO	SHMO	SHMO-D

Line 7 – Enrollee Type. If the bid prices any type of plan covering enrollees eligible for both Part A and Part B of Medicare, enter “A/B”. If the bid prices any type of plan covering enrollees eligible for Part B only, enter “Part B Only”.

Line 8 – MA Region. If the MA plan is a regional PPO (plan types RPPO or RPPO-D), then input the region that the plan will cover. Local plans should leave this blank. For regional plans, valid numeric entries are 1 through 26, as follows:

1	Northern New England (New Hampshire and Maine)
2	Central New England (Connecticut, Massachusetts, Rhode Island, and Vermont)
3	New York
4	New Jersey
5	Mid-Atlantic (Delaware, District of Columbia, and Maryland)
6	Pennsylvania and West Virginia
7	North Carolina and Virginia
8	Georgia and South Carolina
9	Florida
10	Alabama and Tennessee
11	Michigan
12	Ohio
13	Indiana and Kentucky
14	Illinois and Wisconsin
15	Arkansas and Missouri
16	Louisiana and Mississippi
17	Texas
18	Kansas and Oklahoma
19	Upper Midwest and Northern Plains (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming)
20	Colorado and New Mexico
21	Arizona
22	Nevada
23	Northwest (Idaho, Oregon, Utah, and Washington)
24	California
25	Hawaii
26	Alaska

Line 9 – Actuarial Swap or Equivalences (Employer Group Health Plans only). If the plan will use actuarial swaps or equivalences on its EGHP plans, enter "Y". Otherwise, enter "N". Note that bids submitted for non-EGHP plans (plans with IDs other than the 800-series) must enter "N" since actuarial swaps and equivalences only apply to EGHP plans. See Appendix D for further information.

Line 10 – Region Name. No user input is required.

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition. Enter the base period experience incurral information on the first two lines. In addition to the incurral dates, enter the "paid through" date. For example, if the incurral period is calendar year 2004, the "incurred from" date is 1/1/2004 and the "incurred to" date is 12/31/2004. If the data is from payment information through February 2005, then the "paid through" date is 2/28/2005. Note that the base time period incurral data is not required to be a calendar year.

Line 2 – Member Months. – Enter the number of member months represented in the base period experience used.

Line 3 – Non-ESRD Risk Score. Enter the plan's risk score, as of the mid-point of the period, underlying the base period data. The 100% HCC risk score for non-ESRD members must be used.

Line 4 – Demographic Score. Enter the plan's demographic score for non-ESRD as of the mid-point of the period, underlying the base period data.

Line 5 – Completion Factor. Enter the factor used to adjust the paid data to an incurred basis. The base period data must represent the best estimate of incurred claims for the time period, including any unpaid claims as of the "paid through" date. The factor shown must be the amount to adjust only the portion of paid claims which require completion (e.g., omit capitations from the calculation of this factor).

For example, assume:

Incurred Dates:	1/1/04 – 12/31/04
Paid Thru Date:	2/28/05
Capitations Paid in 2004:	$100
PTD Claims Requiring Completion	$400
Estimate of Unpaid Claims as of 2/28/05	$30
Total Incurred Claims in 2004	$530

The Completion Ratio would be Calculated as:
Completion Ratio = (400 + 30) ÷ 400 = 1.075

Line 6 – Plans in Base. Enter the contract number and plan ID (in the format H9999-999) of that plans (maximum of four) that are included in the base period data. In the second column, input each plan's percentage of the total member months reported in Line 2.

Line 7 – Base period description. Use the text box provided to briefly describe the base period data. The base period data need not reflect the same benefit plan or service area as the contract year. Do not adjust data for credibility, which is addressed on the Projected Allowed Cost Worksheet with the manual rate. Examples of different base period data include:

- Same benefit plan, but larger or smaller service area.
- Same benefit plan, but an entirely different service area.
- Similar benefit plan in same or different service area.
- Benefit plan with similar in-network benefits/cost sharing.

SECTION III – BASE PERIOD DATA AT PLAN'S NON-ESRD RISK FACTOR

Section III summarizes the base period data by service category. Please note that these data:

- Need *not* exactly match the benefit plan or service area for the bid (see Section II instructions).
- Reflect either calendar year or other annualized experience
- Reflects the current best estimate of incurred claims including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on the Required Revenue worksheet).
- Includes any provider incentive payments.
- Includes total services (both in-network and out-of-network).
- Must be before reduction for member cost sharing and reinsurance recoveries (that is, the data must reflect experience on an allowable basis).
- Must exclude the value of benefits added to EGHP plans as a result of negotiations with employers.
- Capitations must be allocated to the appropriate service category line on a reasonable basis.

Note that the service category lines may include both Covered and A/B mandatory supplemental services (e.g., line A, Inpatient Facility). Alternatively, some lines are entirely Covered services (e.g., line J, Part B Rx) or entirely A/B mandatory supplemental services (e.g., lines L through R). The COB/Subrogation line (line S) is intended to include only those amounts settled outside the claim system. If an MAO pays claims for its estimated liability only (i.e., net of the amount that is the responsibility of another payer such as an employer plan or auto policy), the MAO's net liability amount (before cost sharing reductions) may be entered on lines A through R. This is a change from instructions in prior periods when the detail service claims were to be reported at the full amount (i.e., including other payer liabilities) and the full COB amount used. Both methods result in the same total allowed cost across all service categories including COB.

Column a, Lines A through R – **Utilization type**. The type of utilization measure is entered in column a. For each line item, enter the appropriate measurement unit from the list below.

- A – Admits
- D – Days
- BP – Benefit Period
- V – Visits
- P - Procedures
- T – Trips
- S – Scripts
- O - Other

Column b, Lines A through R – **Annualized Util/1,000.** Enter the annualized utilization per thousand enrollees for each of the service categories for the base period. The utilization must be reported consistently with the utilization type entered in column a.

Column c, Lines A through R – **Avg Cost.** These cells are calculated using the utilization provided in column b and allowed PMPM information provided in column d.

Column d, Lines A through S – **Allowed PMPM**. Enter the allowed PMPM by service category in column d. Line S (COB) must be input as a negative number.

Line 20 – Total Medical Expenses. Calculated as the sum of lines A through S.

Line 21 – Subtotal Medicare-covered services. Calculated as the sum of lines A through K.

SECTION IV – PROJECTION ASSUMPTIONS (COLUMNS E THROUGH K)

Section IV presents the utilization, cost and other adjustment assumptions to project the base period data to the bid contract period. The factors in columns e through i are the total adjustment factor, not annual rates. For example assume the base period is calendar year 2004 and the contract year is 2006. If the utilization trend is 5% from 2004 to 2005 and 6% for 2005 to 2006, enter 1.113 in column e (1.05 x 1.06).

Column e, Lines A through S – **Util/1000 trend**. Enter the expected utilization trend factor from the base period to the bid contract period by service category.

Column f, Lines A through S – **Benefit Plan Change**. Enter any multiplicative benefit plan changes that affect the base period data by service category (e.g., increase in coverage level from base period to contract period).

Column g, Lines A through S – **Population Change**. Enter any expected demographic or morbidity changes that are necessary to adjust the base period data to the projection period.

Column h, Lines A through S – **Other Factor**. Enter any other utilization factor adjustment in column h. Describe the reason for the adjustment in Section V if a factor other than 1.000 is used. Examples of the use of this factor are to adjust the base period service area to the contract year service area or adjust consolidated base period experience to a specific plan option.

Column i, Lines A through S – **Unit Cost/Intensity Trend**. This factor must reflect the anticipated unit cost/intensity trend factor from the base period to the contract period.

Columns j and k, Lines A through S – **Additive Adjustments**. Use these columns to reflect adjustments that are additive versus multiplicative. For example, you might need to delete a benefit that is no longer being offered, but is included in the base period information. In this case, enter the projected utilization or PMPM of the benefit being removed as a negative number in columns j or k respectively. Do not input an additive utilization adjustment for COB (line S, column j) since there is no base period utilization for COB. Describe the reason for any additive adjustments in Section V.

SECTION V – DESCRIPTION OF OTHER UTILIZATION FACTOR AND ADDITIVE VALUES

Use this free text field to describe use of a factor other than 1.00 in column h or any amounts in columns j and k.

Worksheet 2 - MA Projected Allowed Costs PMPM

This worksheet calculates the projected allowed costs for the contract year. For plans without fully credible experience, it will be necessary to input manual rate information. All information provided on worksheet 2 should exclude ESRD enrollees.

The service category lines are the same as those on the Base Period Experience page.

Plan's non-ESRD Risk Factor (for the contract year) – The non-ESRD risk factor is for the contract year and is from the Benchmark page (Worksheet 5).

Lines A through U.

Columns a through c – Projected Experience Rate. Columns a through c are calculated using the information provided in Section III and IV from the MA Base Period Experience and Projection Assumptions Worksheet. No user inputs are needed. Column a calculates the projected utilization, column b is the expected average cost, and column c is the Allowed PMPM. These amounts are shown by service category and represent the experience component of the contract year.

Columns d through f – Manual Rate. If the plan has less than fully credible experience or no experience, it must enter information regarding the manual rate for the bid contract period. Utilization/1,000 assumptions by service category must be entered in column d for lines A through R. The manual's utilization rates must be based on the same "utilization type" input on Worksheet 1 for the base period data. If no base period data was entered on worksheet 1, enter the manual rate's utilization types in worksheet 1. Average costs (column e) will be calculated based on the entries in columns d and f. Amounts must be entered in lines A through S of column f. The considerations listed for the Base Period Experience data also apply here. You must provide a description of the source of the manual rate in line V.

Column g – Experience Credibility Percentage. Enter the experience credibility percentage by service category in column g. This must be between 0% and 99% if the plan is using a manual rate in the projection. The percentage used may vary by service category.

Based on an application of classical credibility theory to Medicare fee-for-service experience, CMS has established a guideline for full credibility of 24,000 base period member months. The formula for partial credibility is the square root of (base period member months / 24,000). (Please note that this formula is a guideline; organizations may use a different credibility approach if appropriate supporting materials are provided.)

For example, if the member months reflected in the experience period equals 6,000, then in the projection of contract year medical expenses, the weight given to actual trended experience would equal 50 percent [calculated as (6,000/24,000)^(1/2)]. Alternatively, 100 percent weight would be given to actual trended experience if there were 30,000 member months during the experience period.

Columns h through j – Contract Year Rate. Columns h through j contain the weighted average of the projected experience rate and the manual rate. The Contract Year Rate will be used to determine the required revenue.

Column k - Out-of-Network Percentage. Enter the percentage of total allowed costs that are expected to be out-of-network for each service line.

Line V – Manual rate description. Use the text box to provide a brief description of the source of the manual rate, including trend assumptions.

Worksheet 3A/3B - MA Projected Cost Sharing PMPM (In- & Out-of-Network)

Worksheets 3A and 3B summarize the expected MA cost sharing for the contract year. All information provided on worksheets 3A and 3B should exclude ESRD enrollees

The first worksheet (3A) summarizes the in-network cost sharing. The following worksheet (3B) summarizes the out-of-network cost sharing. The cost sharing information entered on these pages must tie to the PBP and be easy for CMS to cross-check. In addition to supplying cost sharing information (e.g. copayments, coinsurance, etc), the user must also enter plan level deductible information, if applicable.

Please note that although there are not individual entries for each cost sharing item listed in the PBP, the value of all cost sharing items must be reflected in the total PMPM amount.

SECTION I – MAXIMUM COST SHARING PER MEMBER PER YEAR

Exclude any member premium and any Part D premium/cost sharing.

Line 1 - In-Network Cost Sharing Maximum Per Member Per Year. Enter the maximum total dollar amount that a member could pay in-network for the contract year.

Line 2 – Out-of-Network Cost Sharing Maximum Per Member Per Year. Enter the maximum total dollar amount that a member could pay out-of-network for the contract year.

Line 3 - Combined Cost Sharing Maximum Per Member Per Year. Enter the maximum total dollar amount that a member could pay in the contract year for cost sharing both in- and out-of-network.

Line 4 - Maximum Cost Sharing Description. In the text box provided, briefly explain the methodology used to reflect the impact of maximum cost sharing as detailed in Sections II and III.

SECTION II – DEVELOPMENT OF IN-NETWORK COST SHARING PMPM (CONTRACT YEAR, PLAN'S NON-ESRD RISK FACTOR)

Section II summarizes the in-network cost sharing. The service categories are the same as presented for the Base Period Experience Data, except that line S (COB) has been omitted. However, for some services categories (i.e., inpatient), there is more than one cost sharing line available. This allows the user to enter multiple cost sharing items in a service category to better match the PBP. In addition to the lines presented, the user may also use the ten blank lines to include additional cost sharing items that do not fit into an already defined service category line item. Do not insert any additional rows.

Example 1: The PBP contains inpatient cost sharing of $100 per day for both Acute and Psychiatric stays with no maximum cost sharing. Assume that the total inpatient utilization/1,000 is 2,000 days, whereby 1,900 days are for acute and the remaining 100 days are for psych. This could be reflected in the bid form in either of the following ways:

Option A:

	Column e	Column h	Column i
Line A1 – Acute	1,900	$100.00	$15.83
Line A2 – Mental Health	100	$100.00	$ 0.83
Total	2,000	$100.00	$16.67

Option B:

	Column e	Column h	Column i
Line A1 – Acute	2,000	$100.00	$16.67
Total	2,000	$100.00	$16.67

Example 2: The PBP has professional copays of $10 for PCP, $20 for specialists excluding mental health (MH) services, $20 copay for MH group sessions and $40 copay for individual MH sessions. There is no maximum cost sharing. Assume office visit utilization is distributed as follows:

- PCP 5,000
- MH – Indiv. 50
- MH – Group 50
- Other Spc 2,900
- Total 8,000

Some of the options which could be used to complete the bid form are:

Option A: Use finest level of detail, with individual metal health in line I3 and group mental health in line I6.

	col e	col h	col i
Line I1 – PCP	5,000	$ 10.00	$ 4.17
Line I2 – Specialist excl MH	2,900	$ 20.00	$ 4.83
Line I3 – Mental Health	50	$ 40.00	$ .17
Line I6 – Other	50	$ 20.00	$ .08
Total	8,000	$ 13.88	$ 9.25

Note that one of the blank rows at the bottom of the form could also be used to enter one of the mental health copays.

Option B: Same as Option A, but combine the individual and group mental health copays onto line I3.

	col e	col f	col h	col i
Line I1 – PCP	5,000		$ 10.00	$ 4.17
Line I2 – Specialist excl MH	2,900		$ 20.00	$ 4.83
Line I3 – Mental Health	100	$20/40	$ 30.00	$ .25
Total	8,000		$ 13.88	$ 9.25

Option C: Enter all services on one line (for ex., I2 or I6) using average copays.

	col e	col f	col h	col i
Line I2 or I6	8,000	$10-$40	$ 13.88	$ 9.25
Total	8,000		$ 13.88	$ 9.25

Column a. This column is completed for most of the available rows. If you wish to use the blank rows at the bottom, the eligible categories are:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- OP Facility – Emergency
- OP Facility – Surgery
- OP Facility – Other
- Professional
- Part B Rx
- Other Medicare-covered
- Transportation (Non-Covered)
- Dental (Non-Covered)
- Vision (Non-Covered)
- Hearing (Non-Covered)
- POS
- Health & Education
- Other Non-Covered

Column b. Column b provides a description or note for many of the fixed line cost sharing items. For lines with multiple options (e.g., inpatient) the description is there to help the user determine which line is best suited for the cost sharing. The user may input a description if using a blank row to enter additional cost sharing lines.

Column c. For each cost sharing line, enter the appropriate measurement unit from the list below.

- A – Admits
- D – Days
- BP – Benefit Period
- V – Visits
- P - Procedures
- T – Trips
- S – Scripts
- O - Other
- Coin - Coinsurance
- Ded – Deductible (only used for single line items such as per benefit period deductibles; deductibles that apply to multiple service categories are entered in the footnote)

The cost sharing utilization type must be consistent with the contract year utilization type for allowed costs on Worksheet 2.

Column d. If there is a plan level deductible, the effective amount of the deductible must be entered on each line item affected. For example, for each service that is subject to the deductible, an amount needs to be entered in column d such that the subtotal represents the effective PMPM value of the deductible. The actual plan level deductible amount (e.g., $500) must also be entered in the footnote.

Column e. Enter the projected utilization (or PMPM value in the case of coinsurance) in column e for each cost sharing line after the deductible has been satisfied.

Column f. Enter the value of the copayment or coinsurance for each service category listed. Include any notes such as “for 1st 5 days”. This is a text field. All descriptions entered must be easily matched back to the PBP. However, if the entry in column f would be the same as column g, then column f could be left blank. That is, column f would be filled in only if the value is different from the value in column g.

Column g. Enter the projected effective cost sharing amount after the deductible has been satisfied but before any adjustments for maximum cost sharing.

Column h. Enter the projected effective cost sharing after the deductible has been satisfied and after any adjustments for maximum cost sharing. This is the amount that will be used to calculate the cost share PMPM.

Column i. These cells are automatically calculated. Column i is the projected cost sharing value PMPM for in-network services excluding the effective plan level deductible. The formula uses the utilization or PMPM amounts in column e along with the effective cost sharing amounts after adjustments for maximum cost sharing in column h.

- If measurement unit is “coinsurance”, calculation is column e times column h.
- For measurement units other than “coinsurance”, calculation is column e times column h divided by 12,000.

Column j. These cells are automatically calculated. This column illustrates the results of the in-network cost sharing development. Column j is the total projected cost sharing for in-network services.

SECTION III – DEVELOPMENT OF OUT-OF-NETWORK COST SHARING PMPM (CONTRACT YEAR, PLAN’S NON-ESRD RISK FACTOR)

The worksheet has the same inputs as the in-network cost sharing development (Section II).

Worksheet 4 - MA Projected Revenue Requirement PMPM

This worksheet uses the information developed on the previous worksheets for the allowed costs PMPM (Worksheet 2) and cost sharing PMPMs (Worksheets 3A/3B) to determine net medical costs. Non-medical costs and gain/loss margins are added to establish the required revenue for the contract year. Values are also allocated between Medicare-covered benefits and A/B mandatory supplemental benefits. All values reflect the plan's non-ESRD risk factor.

This page has few user inputs. The user must enter the expected percentage for Covered services for allowed dollars and cost sharing for each service line. The user must also enter non-medical expense amounts and gain/loss amounts on this page. All information provided on worksheet 4 should exclude ESRD enrollees

In addition to calculating the total required revenue, this page also provides some key statistics which show the net medical expense, non-medical expense and the gain/loss margin as a percentage of revenue. Section II contains a test to confirm that a plan's cost sharing value PMPM is within the limit (i.e., does not exceed original Medicare cost sharing).

SECTION I – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

Lines A through S – The same service category lines are used as in previous worksheets. The calculations by column are:

> **Column a**. The allowed PMPM is obtained from the Projected Allowed Costs worksheet. No user inputs are necessary in column a.
>
> **Column b**. Column b summarizes the total in- and out-of-network cost sharing PMPMs from the previous two worksheets for each service category. No user inputs are necessary in column b.
>
> **Column c**. The Net Medical Cost PMPM is calculated as column a less column b.
>
> **Columns d and e - % for Cov. Svcs.** The PMPM amounts in columns a through c are for all benefits covered by the MA plan. Columns d and e represent the expected percentage for Medicare-Covered services. For example, for inpatient hospital, the plan might estimate that the PMPM in column c represents 99.9% of Medicare-Covered services and 0.1% for A/B mandatory supplemental benefits. For lines L through R where the services are non-covered as defined, the percentage is set at 0.0%. For lines A through K and S, the plan must estimate the percentage of covered services for both the allowed costs and cost sharing. The user must enter these percentages in columns d and e.
>
> For "Part B Only" plans, the percentage for inpatient services (lines A and B) should be equal to 0%. Home Health services (line C) should be approximately 50%, which represents the national average portion of Medicare covered Home Health provided under Part A.

Column f – Fee-for-service Medicare Actuarial Equivalent (AE) cost sharing proportions. These values are pre-populated by CMS for lines A through R.

Column g – Plan cost sharing for Medicare-covered services. Calculated as column e x column b.

Columns h through j – Medicare Covered using actuarial equivalent (AE) cost sharing. These columns show the allowed PMPM, FFS AE cost sharing PMPM and net PMPM for Medicare-covered services only. These columns are calculated automatically.

Columns k through m – A/B Mandatory Supplemental Benefits. The amounts are calculated automatically.

Line T – Total Medical Expenses. The total medical expense is the sum of lines A through S, except as noted above for column f.

Line U – Non-Medical Expenses. The user must enter the Non-Medical expense information for total MA benefits and for A/B mandatory supplemental benefits in columns c and m, respectively. The non-medical expenses for Medicare Covered benefits (column j) is calculated as the difference between the total (column c) and the A/B mandatory supplemental (column m). The Non-Medical expenses must be shown separately for the following categories:

- Marketing & Sales
- Direct Administration (for example, functions that are directly related to the administration of the Medicare Advantage program, such as customer service, billing and enrollment, medical management, claims administration, etc.)
- Indirect Administration (for example, functions that may be considered “corporate services”, such as CEO, accounting operations, actuarial services, legal services and human resources)
- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries)
- Medicare User Fees
- Uncollected Enrollee Premium

We would expect that the non-medical expenses would be distributed proportionately between Medicare Covered and A/B mandatory supplemental.

All non-pharmacy expenses must be reported using the appropriate generally accepted accounting practice (GAAP) methodology. Guidance on GAAP standards are promulgated by the Financial Accounting Standards Board (FASB). Of particular applicability is FASB’s Statement of Financial Accounting No. 60, Accounting and Reporting by Insurance Enterprises.

For example, capital expenditures must be deferred and amortized consistent with the relevant GAAP standards. Also, acquisition expenses (marketing and sales) must be deferred and amortized consistent with the revenue stream anticipated on behalf of the newly enrolled members.

Line V – Gain/Loss Margins. The user must input the projected PMPM for the gain or loss in column c for total services and column m for A/B mandatory supplemental services. Column j calculates the gain/loss for Medicare Covered services as column c minus column m.

We would expect that the gain/loss margin would be distributed proportionately between Medicare Covered and A/B mandatory supplemental.

Consistent with statutory intent, the gain/loss margin must reflect the revenue requirements of benefits provided under the plan. CMS will assess the reasonableness of the gain/loss margin relative to other MA bids. Organizations will be required to provide justification of the margin for bids with relatively large projected gains/losses. Examples of support to be provided are: (i) illustration of return on investment / equity requirement(s), (ii) demonstration of corporate return requirement(s), or (iii) other appropriate actuarial support.

Line W – Total Revenue Requirement. The sum of lines T, U7, and V.

Lines X – Ratios. These lines calculate some key ratios including the ratio of net medical expense, non-medical expenses and gain/loss as a percentage of revenue.

SECTION II – COMPARISON OF COST SHARING FOR COVERED SERVICES WITH FFS MEDICARE

This section computes whether a plan's cost sharing value PMPM is within the allowable limit (i.e., does not exceed original Medicare cost sharing). No user inputs are required. However, if the plan's cost sharing does not fall within the allowable limit, the plan must provide supporting documentation to CMS.

Worksheet 5 - MA Benchmark PMPM

This worksheet calculates the A/B benchmark and evaluates whether the plan realizes a savings or needs to charge a basic member premium. All information provided on worksheet 5 should exclude ESRD enrollees

Below is a brief description of the sections contained in this worksheet:

- Section I - Outlines the development of the benchmarks and bids.
- Section II - Outlines the development of the Savings or Basic Member Premium.
- Section III - Blend of risk and demographic payment methodologies.
- Section IV - Summary of Statutory Component of Regional Benchmark.
- Section V – Summary of Section VI.
- Section VI - Projected (plan specific) information for counties within the service area.

The A/B benchmark calculation is based on the following data elements:

- Service Area: Counties within the MA service area defined by their respective Social Security Administration (SSA) State-county codes (Section VI, column a).
- Projected Membership: Projected average monthly membership by county by Aged and Disabled (Section VI, columns d, e, f).
- Projected Demographic and Risk Factor (excluding ESRD): Projected average demographic and risk factor for projected non-ESRD enrollees by Aged and Disabled (Section VI, columns g through i).
- Working Aged Adjustment Factor: Factor relative to all payments (Section I, line 2).
- Risk/Demographic Weighting: Blend of risk and demographic factor adjustments (Section III).
- The mix of Medicare beneficiaries (nationally) between original Medicare and Medicare Advantage – used to weight the statutory and plan bid components of the regional A/B benchmark.

The data entries and calculations by line are documented below.

SECTION I – BENCHMARK AND BID DEVELOPMENT

Line 1 – Standardized A/B Benchmark (at 1.000). This value is from Section IV line 3 for regional plans or Section V line 1 for local plans.

Line 2 – Working Aged Adjustment Factor. – Can be calculated as the ratio of total working aged adjustment dollars divided by total payments before reduction for user fees or working aged. (Do not use the working aged rate on the plan payment reports since that value is only applied to payments to aged members.) User inputs are required in the first two columns.

Line 3 – Weighted Average Demog/Risk Adjustment Factor (excl ESRD). This value is from Section V line 1 for demographic or Section V line 2 for risk.

Line 4 – Conversion Factor. Calculated as (1- line 2) times line 3.

Line 5 – Plan (or Regional) A/B Benchmark. Calculation is line 1 x line 4.

Line 6 – Plan A/B Bid. This value is from Page 4.

Line 7 – Standardized A/B Bid (@ 1.000). Calculation is line 6 divided by line 4.

SECTION II – SAVINGS/BASIC MEMBER PREMIUM DEVELOPMENT

Line 1 –Savings. The difference between the Plan (or Regional) A/B Benchmark (Section I, line 5) and the Plan A/B Bid (Section I, line 6), but not less than zero.

Line 2 – Rebate. This value is defined as 75% of the Savings.

Line 3 – Basic Member Premium. The Standardized A/B Bid (Section I, line 7) less the Standardized A/B Benchmark (Section I, line 1), but not less than zero.

SECTION III – RISK/DEMOGRAPHIC WEIGHTING

Line 1 – Risk. The percentage weighting applied to the risk factor adjustment. This is a fixed percentage applied to all plans in the contract year. No input is required.

Line 2 – Demographic. Calculation is 1 – line 1.

SECTION IV – STANDARDIZED A/B BENCHMARK – REGIONAL PLANS (BEFORE BONUSES)

This section calculates the standardized A/B benchmark for regional plans (before bonuses).

Line 1 – Statutory Component. The PMPM amount defined by region is determined by CMS. The weighting is pre-determined by CMS.

Line 2 – Plan Bid Component. This will be provided by CMS after the regional bids are submitted. However, plans may input an estimated amount. Plans may need to resubmit the bid form when the final amount is determined by CMS.

Line 3 – Standardized A/B Benchmark – Regional Plans (before bonuses). The calculation is the weighted average of lines 1 and 2 (if line 2 has a value). If line 2 does not have a value (i.e., for initial bid submission with no plan estimate), the amount from Section I, line 7 is used in its place.

SECTION V – GRAND TOTAL/OVERALL WEIGHTED AVERAGE (SUMMARY OF SECTION VI)

This section shows the total weighted average of the various components of Section VI (i.e., including Aged, Disabled, and Risk).

Line 1 – Demographic Ratebook. Calculates the weighted average of the demographic ratebook rates, based on projected enrollment.

Line 2 – Risk Ratebook. Calculates the weighted average of the risk ratebook rates, based on projected enrollment.

Line 3 – Grand Total Projected Average Members. Total projected enrollment, based on Section VI.

SECTION VI – COUNTY LEVEL DETAIL AND SERVICE AREA SUMMARY

This section contains detailed data by county. For most plans, the only user inputs are the state/county code, projected enrollment and demographic and risk factors. Entries must reflect plan-specific enrollment projections for each county within the service area.

CMS is considering allowing regional MA organizations, on a case-by-case basis, to request that payment rates be developed using plan-provided geographic intra-service area rate (ISAR) factors in the event that the variation in the MA rates is not an accurate reflection of the variation in a plan's projected costs in its service area. Regional organizations that would like to propose plan-provided ISAR factors should input such amounts in this section, as described below.

Line 1 – Total or Weighted Average for the Service Area by Component. (e.g., Aged/Disabled/Risk). The county level data is weighted by projected enrollment.

Line 2 – County Level Detail and Service Area Summary.

Column a. State/County Code: Enter the Social Security Administration (SSA) State-county codes that define the MA service area.

- Each code entry must include leading zeros. If you enter a non-valid State-county code, an error message will prompt the user to correct the entry.
- If the service area has more than one county, do not leave any blank rows between the first and last State/County codes in column a.
- Do not enter the same State-county code more than once.
- Do not insert rows above the first row of the table. Do not insert rows below the last row of the table. If additional rows are necessary, insert the appropriate number of rows and "copy down" the formulas of columns that do not require user input.
- Do not include the out-of-area (OOA) county, "99999", in this table. OOA enrollees are not represented in the benchmark calculation..

Column b – State. The worksheet will display the applicable State name based on the corresponding SSN State-county code entered in column a. No user entry is required.

Column c – County Name. The worksheet will display the applicable county name based on the corresponding SSN State-county code entered in column a. No user entry is required.

Column d – Demographic Aged Members. Enter the expected average monthly membership for Aged members by county. Entries are input in numeric format and must be greater than or equal to zero. Eligible entries must be rounded to one decimal place.

Column e – Demographic Disabled Members. Same as column d, but for Disabled members.

Column f – Risk Members. Column d plus column e.

Column g – Aged Demographic Factor. Enter the projected Aged demographic factor for the expected members by county. Entries are input in numeric format and must be greater than or equal to zero.

For existing members, the Aged demographic factor can be determined using information contained in the CMS Monthly Membership Report data files. The Aged demographic factor is the ratio of (i) actual plan payments, aggregated by county, associated with the Aged demographic component of the county specific Aged rate published in the Rate Book to (ii) the sum of the corresponding unadjusted Aged demographic Rate Book values. The development of these values should include both payments and adjustments. Further, the factors should reflect appropriate adjustments to account any for any changes from the experience month to the projection period.

The Aged demographic factors must be projected for new plans or new counties within the service area where no historical payment information is known regarding actual enrolled members. Aged demographic factors can also be projected for existing plans if the MAO expects the membership mix to change for the projection period.

Support for the demographic factors must be available upon request.

Column h – Disabled Demographic. Same as column g, but for Disabled members and Disabled ratebook.

Column i – Non-ESRD Risk. Same as column g, but for Aged and Disabled members combined and using the Risk ratebook. In addition to consideration of the changing risk profile of population, factors should be adjusted to reflect assumed impact of “coding intensity.”

Columns j through l – Plan-provided ISAR factors. CMS may allow regional MA organizations, on a case-by-case basis, to request that payment rates be developed using plan-provided geographic intra-service area rate (ISAR) factors in the event that the variation in the MA rates is not an accurate reflection of the variation in a plan’s projected costs in its service area.

Regional organizations that would like to propose plan-provided ISAR factors should complete the following steps:

(i) Enter “yes” in the first row of column l, in response to the question: “Use of plan-provided ISAR?”

(ii) Enter the plan-provided ISAR factors in columns j through l of the county level detailed table. Factors can either be in the form of a PMPM value or a relative scale. Also, different factors can be used for each ratebook type (demographic aged, demographic disabled, and risk) or the same set of factors can be used for all ratebook types.

(iii) Organizations that use plan-provided ISAR factors must provide support for their development in accordance with Appendix B.

Columns m through o – MA Ratebook (Unadjusted). The worksheet will display the applicable published rate book rates for Aged, Disabled, and Risk. If enrollee type is “A/B”, the amounts shown are the total of Part A and Part B. If enrollee type is “Part B-only”, the amount is the Part B portion only.

Columns p through r – MA Ratebook: Risk-Adjusted. The worksheet will calculate the risk-adjusted rates based on the ratebook rates in columns m through o, and the factors input in columns g through i.

Columns s through u – ISAR-adjusted bid, The worksheet will calculate the ISAR-adjusted bid based on the ratebook rates in columns m through o, and the Standardized A/B bid in Section I. Please note that the payment rates represent coverage for Medicare Part A and Part B (except in for Part-B only plans). The values will then be segregated into Part A and Part B rates in columns ag through al.

Columns v through x – ISAR scale. The worksheet will calculate the ISAR scale based on either the plan provided ISAR factors in columns j through l (if provided) or the ratebook rates in columns m through o.

Columns y through ab – Original Medicare cost sharing. These columns will be pre-populated by CMS.

Columns ac through af – FFS costs to weight Original Medicare cost sharing. These columns will be pre-populated by CMS.

Columns ag through al – Payment rates. These columns are automatically calculated.

Columns am through an – FFS equivalent cost sharing. These columns will be pre-populated by CMS.

Worksheet 6 – MA Bid Summary

The summary worksheet contains the results of calculations from the bid form. In addition, there are some user inputs, as described below.

SECTION I – GENERAL INFORMATION

Note: Lines 1 through 7 are obtained from Worksheet 1.

Line 8 – Estimated Part B Premium in Contract Year. The bid form has a preloaded value. MA enrollees are required to pay the Part B premium, unless it is reduced or eliminated by the MA organization through the use of rebate dollars. The amount shown is the estimated value of the Part B premium for the contract year at the time the bid form is released. If a better estimate or the final value is known prior to submitting the bid, the value can be changed.

Line 9 – Part B % of USPCC. This line is preloaded by CMS. If your plan is submitting a "Part B Only" bid, this percentage is used to estimate the Part A portion of the CMS benchmark. The Part A portion of the CMS benchmark is one of the tests for the maximum amount the MAO may charge Part B-only members for Part A benefits.

Line 10 – Maximum for Part A Package on Part B-Only Members. Lines a through c do not require any user inputs. These lines use other bid information to calculate the maximum for Part A services that can be charged to Part B-only members. On line d, enter the premium you will charge Part B Only members for Part A services. The amount in line d cannot be greater than the minimum of the values in lines a – c. If you are not submitting a "Part B Only" bid, ignore this line item.

SECTION II – PLAN A/B BID SUMMARY

Section II summarizes the bid information in three parts. Section A is the Overview, Section B contains the MA Rebate Allocation, and Section C develops the premium for A/B mandatory supplemental benefits. Consistent with previous worksheets, please note that any optional supplemental benefits are excluded.

Section A – Overview

This section summarizes the detail underlying the required revenue for the plan.

Line 1 – Allowed medical cost. The allowed PMPM at the plan's contract year non-ESRD risk factor. These amounts are obtained from the Required Revenue page (Worksheet 4).

Line 2 – Cost Sharing. This value is obtained from the Required Revenue worksheet.

Line 3 – Net Medical Cost. The sum of lines 1 and 2.

Line 4 – Non-Medical Expenses. The Non-Medical expenses are obtained from the Required Revenue page.

Line 5 – Gain/Loss Margin. This is the estimated net gain/loss for the plan and is obtained from the Required Revenue page. This includes the amount of risk margin desired.

Line 6 – Total Revenue Requirement. The sum of lines 3 through 5. This is the required revenue at the plan's non-ESRD risk factor. This amount is calculated prior to any rebate allocation.

Section B – MA Rebate Allocation

This section illustrates how the rebate is applied to the various options:

- Reduce A/B cost sharing.
- Other A/B Mandatory Supplemental Benefits.
- Reduce Part B premium.
- Reduce Part D premium Basic.
- Reduce Part D premium Supplemental.

Line 1 – MA Rebate. The amount calculated on the benchmark page (worksheet 5) is shown on this line.

Lines 2 through 6: In the fourth column, enter the portion of the rebate allocated to each of the rebate options. The first three columns distribute the allocated rebate among medical expenses, administrative expenses and gain/loss. The fifth column shows the maximum amount that may be applied for each option. No maximum value is supplied for lines 5 and 6 since those amounts are based on the Part D bid form. The upload submission will check that the allocation entered does not exceed the maximum allowable.

Line 7 – The sum of lines 2 through 6. This amount must equal the amount in line 1.

Section C – Development of A/B Mandatory Supplemental Premium

Line 1 – A/B Mandatory Supplemental revenue requirements. This amount is obtained from Section IIA, line 6 for A/B mandatory supplemental services.

Line 2 – Rebate Allocations. These amounts are obtained from Section IIB, lines 2 and 3.

Line 3 – PMPM ESRD Loss per plan enrollee. This amount is obtained from Section V.

Line 4 – A/B Mandatory Supplemental premium. The sum of lines 1 through 3.

Line 5 – Basic Premium. This amount is obtained from page 5

Line 6 – Total Enrollee Premium (excl. Optional Supplemental). The sum of lines 4 and 5.

SECTION III – SUMMARY AT PLAN'S NON-ESRD RISK FACTOR

This section does not require any user input and summarizes information from other sections of the bid form. The amounts shown are at the plan's non-ESRD risk factor and provide an overall summary of the contract year values in a typical income statement format. It also includes some key statistics. The amounts in this section exclude optional supplemental benefits and are before taxes and investment income.

Line 1 – Revenue.

a. **Plan A/B Bid.** This amount is obtained form worksheet 5.
b. **A/B Mandatory Supplemental Premium.** Equal to Section IIC, line 4.
c. **MA Rebate Applied to A/B**. This amount is obtained from Section IIB, lines 2 and 3.
d. **Total**. The sum of lines 1a through 1c.

Line 2 – Net Medical Expense. The net medical expense is obtained from the Required Revenue worksheet and is shown for Medicare-covered services and A/B mandatory supplemental benefits. Also, the PMPM cost for ESRD enrollees from IIC is included.

Line 3 – Non-Medical Expense. The non-medical expense is obtained from the Required Revenue worksheet.

Line 4 – Gain/Loss. The gain/loss PMPM is obtained from the Required Revenue worksheet.

Line 5 – Key Statistics. The key statistics shown are average monthly enrollment, contract year non-ESRD risk factor, loss ratio, non-medical ratio and gain/(loss) margin. Lines 5a and 5b are from the benchmark page. Lines 5c through 5e are calculated based on lines 1-4 above.

SECTION IV – DEVELOPMENT OF RISK SHARING TARGET (REGIONAL PLANS ONLY)

This section calculates the medical loss ratio target, based on the information contained in the bid. It is applicable to regional plans only. No user inputs are required. However, in accordance with Appendix B – Supporting Documentation, organizations must provide as a supporting exhibit a description of the adjustments that will be made to medical costs reported in general ledger to account for (i) any differences in the level of cost sharing reflected in the risk sharing target and that required of plan enrollees, and (ii) the methodology to be used to capture expenditures for non-Covered services that are implicitly included in the risk sharing target.

SECTION V – DEVELOPMENT OF PMPM ESRD LOSS PER PLAN ENROLLEE

This section calculates the PMPM ESRD loss per plan enrollee, used in Section IIC. 6.

Line 1 – PMPM ESRD payment from CMS. Enter the projected payment from CMS per ESRD enrollee.

Line 2 – Monthly basic & supplemental premium. Calculated automatically based on the Basic and A/B Mandatory Supplemental Premiums.

Line 3 – PMPM ESRD net medical expenses. Enter the total projected net medical expenses per ESRD enrollee.

Line 4 – PMPM loss per ESRD enrollee. Calculated as line 1+ line 2 – line 3.

Line 5 – Projected average enrollment - ESRD. Enter the projected average ESRD enrollment.

Line 6 – Projected average enrollment – all enrollees. Calculated as line 5 + Section III line 5a.

Line 7 – PMPM ESRD loss per plan enrollee. Calculated as line 4 x line 5, divided by line 6.

SECTION VI – CONTACT NAMES

Enter the name, position, phone number and email information for the plan contact as well as the certifying actuary in this section. For the phone number, please enter all 10 digits consecutively without parentheses or dashes. Also, if a contact person has no email service, please enter "none".

The person named as the plan contact must be available for any actuarial issues that arise during CMS' review of the bid form.

The actuarial certification must be submitted electronically to CMS.

Worksheet 7 – Optional Supplemental Benefits

This worksheet contains the actuarial pricing elements for any optional supplemental benefit packages to be offered during the contract year.

The worksheet allows for 5 optional supplemental packages to be priced, with 20 category lines for each package. If additional category lines are needed, please provide a supporting exhibit that shows all of the benefit category details, and include a summary of those category lines on this worksheet. If additional packages are offered, please provide a supporting exhibit for the additional packages. Do not insert any additional rows to the form.

Column a – **Package ID.** An identification (ID) number to signify which package of optional supplemental benefits is being reported. 001 is used to identify the first package. Whole numbers in sequence (for ex., 002, 003) identify additional packages of optional supplemental benefits

Column b – **Service Category.** Enter the service category. Valid entries are those consistent with the categories included on Worksheet 1:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- OP Facility – Emergency
- OP Facility – Surgery
- OP Facility – Other
- Professional
- Part B Rx
- Other Medicare-covered
- Transportation (Non-Covered)
- Dental (Non-Covered)
- Vision (Non-Covered)
- Hearing (Non-Covered)
- POS
- Health & Education
- Other Non-Covered

Column c – Benefit Category or Pricing Component. Enter applicable pricing benefit category or pricing component.

Column d – **Utilization type.** Enter the appropriate measurement unit from the list for column a, Worksheet 1.

Column e – **Annual utilization/1,000**. Enter the projected annual utilization per thousand enrollees for each benefit category.

Column f – **Average allowed cost**. Enter the projected average allowed cost for each benefit category.

Column g – **Allowed PMPM**. Column g is calculated using the utilization reported in column e and average cost information reported in column f.

Column h – **Measurement unit code.** Enter the appropriate cost sharing measurement unit using the codes provided for column c, Worksheet 3A/3B.

Column i – **Utilization or PMPM.** Enter the projected utilization per thousand (or PMPM value in the case of coinsurance).

Column j – **Average cost sharing** Enter the projected average per-service cost sharing amount, or coinsurance percentage.

Column k – **Cost sharing PMPM.** Column k is calculated using the utilization reported in column i and average cost information reported in column j.

Column l – **Net PMPM value.** Column l is calculated as the allowed PMPM (column g) minus the cost sharing PMPM (column k).

Column m – Non-Medical expense. Enter the total projected non-medical expense for each optional supplemental package offered.

Column n – Gain/Loss Margin. Enter the total gain/loss margin for each package.

Column o – Premium. The sum of columns l, m and n

Column p - Projected Member Months. Enter the total projected member months for each optional supplemental package.

Comments. Enter any comments necessary.

Two-Year Lookback Form

The Two-Year Lookback is a separate form that was developed to assist CMS in evaluating the accuracy of previous MA Bids. The form requires the user to input actual incurred revenue and expense information for the calendar year two years prior to the contract year currently being priced. For example, in contract year 2006, the experience year is 2004. CMS will compare the actual amounts recorded to the original projection (for ex., in the 2004 ACR in contract year 2006).

The information must be completed under the following assumptions:

- Data must be provided at the contract level, with separate reporting for individual and employer group (i.e., 800 series plan IDs). Combined individual and employer group results are also required.
- The first two columns will be pre-populated by HPMS. It will be the weighted average of the bid amounts from two years prior, with the weights being the actual member months based on data in the MMR files for that contract.
- The data includes all Medicare Advantage plans offered during 2004, regardless of whether the plan is being offered in 2006.
- The data includes net medical costs only, but additional data is required to allow a review of the level of claim reserves included.
- Data must be on a restated (versus reported) basis. While these data will not match audited GAAP financials, they must tie to an internal financial summary.
- The following data must be excluded:
    - Optional supplemental benefits/revenue.
    - Part D basic and Part D supplemental benefits/revenue.
    - Revenue/claims associated with “extra” employer group benefits.
    - Investment income.
    - Taxes.
- Total Non-medical expenses, as specified by OACT, including bad debt must be included.
- Gain/Loss is calculated as revenue less expenses.

Appendix A – Actuarial Certification

CMS requires an actuarial certification to accompany each bid. A qualified actuary who is a member of the American Academy of Actuaries (MAAA) must complete the certification. The new bid approach is more reliant on actuarial techniques; whereas, many aspects of the preceding ACR approach were more accounting based. The objective of obtaining an actuarial certification is to place greater reliance on the actuary's professional judgment and to hold him or her accountable for the reasonability of the assumptions and projections.

In preparing the actuarial certification, the actuary must consider whether the actuarial work supporting the bid conforms to Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. While other ASOPs will apply, particular emphasis is placed on the following ASOPs:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Rates and Financial Projections for Health Plans: Particular focus is placed on the sections dealing with the Recognition of Benefit Plan Provisions (5.2), Consistency of Business Plan and Assumptions (5.3), Reasonableness of Assumptions (5.4), and Use of Past Experience to Project Future Results (5.5)
- ASOP No. 16, Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans
- ASOP No. 23, Data Quality: Particular focus is placed on Section 5, Analysis of Issues and Recommended Practices, and Section 6, Communications and Disclosures
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage
- ASOP No. 31, Documentation in Health Benefit Plan Ratemaking

The certification must include the following types of information:

- Name of the actuary, including qualifications. The relationship of the actuary to the organization submitting the bid must also be disclosed.
- Purpose of the certification.
- Reliances. If the actuary has relied upon another person for certain assumptions or data, this must be disclosed, and the actuary must obtain a letter of reliance from that person. The reliance letters do not need to be included with the initial bid submission, but must be available upon request and for an audit.
- Limitations and qualifications.
- Certification.

The following is an example of a certification statement. You may revise this language as appropriate for each particular bid.

"I, ___________, am a member of the American Academy of Actuaries and am associated with the firm of ________. I am familiar with the requirements for preparing Medicare Advantage bid submissions and meet the Academy's qualification standards for doing so. This bid has been prepared for the Centers for Medicare & Medicaid Services to approve a benefit plan under a Medicare Advantage contract in calendar year ____ as identified by:

Organization Name:

Contract Number:

Plan ID:

In preparing this bid, I relied upon others for certain data and assumptions as summarized below. A copy of each individual's certification is available upon request.

Name/Title	Affiliation	Data/Information Relied Upon

[insert qualifications, if any]

To the best of my knowledge and judgment, I certify that the:

- Assumptions used are reasonable and are consistent with the current business plan,
- Projection techniques are reasonable,
- Bid has been prepared in accordance with CMS' instructions, and
- Bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries.

The impact of unanticipated events subsequent to the date of this bid submission is beyond the scope of my certification.

____
[Name and credentials]
[Date]

[Address/Phone]

Appendix B – Supporting Documentation

In addition to the standard MA bid form, MAO's must provide CMS with additional supporting material. All data submitted as part of the MA bid process are subject to audit by CMS or any person or organization that CMS designates.

To complete the MA bid form, MAOs will need to complete a series of calculations and enter the results on the appropriate worksheet. Therefore, it is required that any relevant supporting information be summarized and included with the bid submission to CMS. Supporting materials are to be in electronic format (for example, Microsoft Excel, Microsoft Word, or Adobe Acrobat) and will be attached to the bid form as part of the upload process. Organizations will *not* be required to send paper copies of supporting documentation.

CMS requires that the following supporting documentation be included with the bid submission (if applicable):

- Signed actuarial certification.
- Support for the manual rate development (Worksheet 2).
- Support, at the benefit level, for significant projected allowed costs (for example, PMPM > $5.00) for non-covered services (Worksheet 2, lines L – R, columns h – j).
- Detailed description of process for adjusting cost sharing due to maximum out-of-pocket limits (Worksheets 3A/3B).
- In accordance with Appendix D, support for actuarial swaps / equivalence waivers.
- Support for the development of plan-provided ISAR factors, as reported in Worksheet 5, Section VI, columns j through l. Presented should be a description of the methodology and data source used to develop the ISAR scale(s). Additionally, included should be county-level values (such as, unit costs or utilization) that were used in the development of the factors.
- In support of the risk-sharing target for regional plans, a description of the adjustments that will be made to medical costs reported in general ledger to account for (i) any differences in the level of cost sharing reflected in the risk sharing target and that required of plan enrollees, and (ii) the methodology to be used to capture expenditures for non-Covered services that are implicitly included in the risk sharing target

The following additional items are not required to be included with the initial submission, but must be available upon request, and will be reviewed at audit:

- Reconciliation of base period experience with company financial data (Worksheet 1).
- Support for projection assumptions (Worksheet 1).
- Support for cost sharing utilization assumptions and plan level deductible (Worksheets 3A/3B).
- Support for allocation of allowed costs and cost sharing between covered and A/B mandatory supplemental benefits (Worksheet 4).

- Support for cost sharing test if plan does not fall within allowable limit (Worksheet 4, Section II, line C).
- Support for non-medical expense assumptions (Worksheet 4).
- Support for demographic factors and risk factors (Worksheet 5).

CMS may also request additional information as part of the bid review process.

Appendix C – Part B-Only Enrollees

A Medicare beneficiary with Medicare coverage only under Part B cannot elect an MA plan after December 31, 1998, unless they are members of employer or union groups.

However, a Medicare beneficiary (with Part B coverage under Medicare) who was a Medicare enrollee of a Section 1876 contractor on December 31, 1998, shall be considered to be enrolled with that organization on January 1, 1999, if the organization had an MA contract for providing benefits on the latter date. Health benefit coverage that MA organizations provide to such remaining Part B-only enrollees constitutes a separate MA plan (which requires a separate bid submission).

CMS encourages MA organizations to submit as few plans as possible for its pre-1999 Part B-only members, rather than duplicating each of its A/B plans for them. In fact, an MA organization can submit one plan for all its pre-1999 Part B-only members under an MA contract if they are in the same type of plan. In addition, if you offer your pre-1999 Part B-only members the same benefits as A/B members (i.e., members eligible for both Part A and Part B of Medicare) for the same price that you charge to A/B members, you are not required to submit a separate bid for the Part B-only members.

On the other hand, MAOs that enroll Medicare beneficiaries with Part B-only coverage in an employer-only or union-only plan **must** prepare a Part B-only bid. Failure to create a separate B-only plan will result in the rejection of any enrollments submitted on behalf of individuals without Part A by the CMS managed care payment system.

Prepare Part B-only bids in much the same way as you would prepare a bid for Part A/B members.

Appendix D – Actuarial Swaps/Equivalence

Section 617 of the Benefits, Improvements, and Protection Act of 2000 (BIPA) provides authority for CMS to waive or modify requirements that hinder the design of, the offering of, or the enrollment in MA plans under contracts between MA organizations and employers or unions. Please refer to section 130 of Chapter 8 of the *Medicare Managed Care Manual* for more about these waivers.

If your MA plan uses either "actuarial swapping" or the "actuarial equivalence" category of waivers under section 617 of BIPA, please provide the following information.

***Actuarial Swaps*.** If you request the actuarial swapping category of waiver, please identify in your supporting documentation both the benefits that *might* be swapped during negotiations with employers and/or unions *and* the MA plan covering those benefits. You need only identify benefits in your bids that are candidates for swaps. You *do not* have to identify the benefits that you might swap for the candidates. When you make specific swaps in negotiations with employers or unions, in the context of the CMS general approval of your candidates, you can do so without obtaining further approval from CMS for the actual swaps.

Actuarial Equivalence. If you request the actuarial equivalence category of waiver, please provide the following information as supporting documentation:

- the cost sharing amounts you intend to change and the MA plan containing the cost sharing,
- any modification to the premium you will charge, and
- any improvement in the benefit related to the changed cost sharing.

Please retain in your files a package of documents with computations supporting the proposed changes under these two types of waivers. *Do not* include those packages of documents in the backup material you send to CMS.

Glossary of Terms

The Medicare Advantage program uses a number of terms that have specialized meaning. Many of the terms have been used for several years (for ex, Plan Type) and are generally not included in this glossary. The terms included here are primarily those that came about as a direct result of the Medicare Modernization Act (MMA) or the development of the bid form.

<u>A/B Mandatory Supplemental benefits</u> mean health care services not covered by Medicare that an MA enrollee must purchase as part of an MA plan. The benefits may include reductions in cost sharing for Medicare benefits, benefits not covered by Medicare, and Part B and Part D premium buy-downs.

<u>A/B Mandatory Supplemental Premium</u> means the premium charged to an enrollee for A/B Mandatory Supplemental benefits.

<u>Allowed cost</u> is not a term uniquely associated with the MMA, but it is a term not previously used in the Adjusted Community Rate process. Allowed costs are the medical costs before reduction for member cost sharing.

<u>Average 1.000 risk factor</u> represents an average Medicare eligible person by demographic and health status.

<u>Basic Member Premium</u> means the premium charged to an enrollee for A/B services, if the bid is above the benchmark (both on a 1.000 risk factor).

<u>Covered</u> is abbreviation for Medicare-covered services.

<u>EGHP extra benefits</u> are benefits offered to employer groups that are above and beyond what is covered in the MA plan.

<u>Local plan</u> is an MA plan other than a Regional PPO plan. Payment areas are defined by county.

<u>MA</u> means Medicare Advantage

<u>MAO</u> means Medicare Advantage Organization.

<u>MA-PD Plan</u> means an MA plan that offers prescription drug coverage under Part D of the Social Security Act.

<u>MA Rebate</u> equals 75% of savings.

<u>Manual rate</u> is not a term uniquely associated with the MMA, but it is not a term previously used in the Adjusted Community Rate worksheets. Manual rates are used when the base period experience data is deemed to be less than fully credible. In such cases, the projected experience rate is weighted with the estimated costs developed under some other basis (fully credible) in the proportion to which the experience data is deemed credible.

<u>Optional supplemental benefits</u> means health care services not covered by Medicare that an MA enrollee might choose to purchase as a part of an MA plan.

Plan A/B Benchmark means the Standardized A/B Benchmark multiplied by the plan's projected risk factor (for local plans).

Plan A/B Bid means the amount that the MAO estimates as its monthly required revenue to provide benefits for A/B services (at the plan's projected risk factor).

Plan Benefit Package (PBP) means the summary of benefits offered by the MA plan. Health plans fill out a separate form and submit the information to CMS.

Plan Bid Component is the weighted average of the Regional PPO A/B bids (at 1.000) based on projected enrollments.

Prescription drug plan (PDP) means approved prescription drug coverage that is offered under a policy, contract, or plan that has been approved as meeting the requirements specified in the rule and that is offered by an organization that has a contract with CMS that meets the contract requirements under part 423 of this chapter and does not include a fallback plan unless specifically identified as a prescription drug plan.

Regional A/B Benchmark means the Standardized A/B Benchmark multiplied by the plan's projected risk factor (for regional plans).

Regional plan means a coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire regions. An MA regional plan must have a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and must pay for all covered services whether provided in or out-of-network. Payment areas are defined by region.

Reinsurance refers to two different concepts. In the MA program for A/B services, reinsurance refers to the situation where an MAO is ceding risk to commercial carriers. This may also be referred to as private reinsurance. For Part D services, reinsurance refers to the Federal government's coverage of 80% of costs over the catastrophic coverage level.

Savings is the difference between the Plan (or Regional) A/B Benchmark and the Plan A/B Bid (not less than zero).

Specialized MA Plan means any type of MA coordinated care plan that exclusively enrolls special needs individuals.

Standardized A/B Benchmark means the weighted average MA payment rate based on the local plan's projected enrollment. For regional plans, the benchmark is based on the Statutory Component and the Plan Bid Component.

Standardized A/B Bid means the Plan A/B Bid divided by the plan's projected risk factor (i.e., the bid at a 1.000 risk factor).

Statutory Component means the rate used in calculating the regional benchmark, based on regional rates weighted by Medicare eligible beneficiaries.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.